Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS110AGC** 01/04/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5220 RANCHER AVE HEALTH LIFE LLC** LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 000 Y 000 Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations. actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 1/4/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A. No deficiencies were identified. Please retain this statement for your records.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

4B3211

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS110AGC** 09/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5220 RANCHER AVE HEALTH LIFE LLC** LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Y 000 Initial Comments Y 000 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations. actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 8/30/10 to 9/15/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Two resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. Complaint #NV00026286 was substantiated. See Tag Y850 and Y515. Additional regulatory deficiencies were identified and cited. See Tag Y072, Y088, Y103, Y105, Y106, Y108, Y621, Y895, Y923. The facility received a grade of D. The following deficiencies were identified: Y 072 449.196(3) Qualifications of Caregiver-Med SS=E | Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication. including, without limitation, an over-the-counter

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TITLE

(X6) DATE

medication or dietary supplement, the caregiver

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maintain monthly a written schedule that

includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule

expires.

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Based on record review from 8/30/10 to 9/15/10, the facility failed to ensure 1 of 4 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #3 failed to provide documentation of a current two-step TB test).

This was a repeat deficiency from the 4/16/09 State Licensure survey.

Severity: 2 Scope: 2

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. 4Q4G11

This Regulation is not met as evidenced by: Based on record review and interview from 8/30/10 to 9/15/10, the facility failed to ensure

If continuation sheet 6 of 10

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NAC 449.2702

Y 621

SS=D

4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who:

(b) Requires restraint.

Severity: 2 Scope: 2

449.2702(4)(b) Admission Policy

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